STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175454	A. Building B. Wing	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 55 residents. The sample included 16 residents, with two reviewed for advanced directives (a written document which indicated the medical decisions for health care professionals when the person could not speak). Based on observation, interview, and record review, the facility failed to ensure advanced directives were clearly indicated for Resident (R) 37 and R206. Findings included: - R37's physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The POS, dated [DATE], lacked documentation of the resident's advance directives. The Admission Minimum Data Set (MDS), documented the facility admitted R37 on [DATE]. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented the resident required supervision of one staff for all Activities of Daily Living (ADLs) and independent with eating. The admission Care Plan lacked instruction to staff for resuscitation (revive someone from unconsciousness or apparent death) if the resident stopped breathing. Review of R37's physical chart and Electronic Medical Record (EMR) from [DATE] to [DATE] lacked documentation of the resident's resuscitation wishes. On [DATE], at 10:25 AM, Licensed Nurse (LN) H confirmed the lack of advance directives in the resident's physical chart or EMR. LN H stated she would begin Cardiopulmonary Resuscitation (CPR), on all residents in the facility until the advance directives were located or call facility management staff for the code status. On [DATE] at 02:34 PM, Administrative Nurse D confirmed the advanced directives were not available and expected each resident to have documented advance directives on admission and with change of status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Advance Directive policy documented facility staff would assist all residents and/or representative to prepare advanced directives. The resident's physician will be notified of the resident's (representative's) wishes and agreement with the advance directives and will be included in the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The facility failed to clearly identify R37's advanced directives in her EMR, placing the resident at risk for receiving inappropriate care. - R206's POS, dated [DATE], documented diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The POS, dated [DATE], lacked documentation of the resident's advance directives. The Admission MDS, dated [DATE], documented the facility admitted R206 on [DATE]. The MDS documented the resident had a BIMS score of 10, indicating moderately impaired cognition. The MDS documented the resident required one staff assistance with dressing, toilet use, and bathing and independent with transfers, bed mobility, ambulation, and eating. The Admission Care Plan, dated [DATE], lacked instruction to staff for resuscitation if the resident stopped breathing. Review of R206's physical chart and EMR, dated [DATE] to [DATE], lacked documentation of the resident's resuscitation wishes. On [DATE] at 10:25 AM, LN H confirmed the lack of advance directives in the resident's physical chart or EHR. LN H stated she would begin CPR, on all residents in the facility until the advance directives were located or call facility management staff for the code status. On [DATE] at 02:34 PM, Administrative Nurse D confirmed the advanced directives were not available and expected each resident to have documented advance directives on admission and with change of status. The facility's undated Advanced Directive policy documented facility staff would assist all residents and/or representative to prepare advance directives. The resident's physician will be notified of the resident's (representative's) wishes and agreement with the advance directives will be included in the resident's clinical record. The facility failed to clearly identify R206's advanced directives in his EMR, placing the resident at risk for receiving inappropriate care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 55 residents. The sample included 16 residents, with one resident reviewed for comprehensive care plan. Based on observation, interview, and record review, the facility failed to develop a comprehensive plan of care for Resident (R) 204. Findings included: - R204's physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition. The MDS documented the resident required total assistance of one or two staff for bed mobility, transfers, dressing, eating, and toilet use. The MDS documented the resident received nutrition via tube feeding, used a wheelchair for mobility, incontinent of bowel and bladder, and a pressure reducing device to his chair and bed. The Communication Care Area Assessment (CAA), dated 08/30/19, documented the facility admitted the resident for [CONDITION(S)] activity, that affected his self-care ability and altered his mental status. The CAA documented the resident was alert and able to answer simple and direct questions at times, and lethargic (weak or sluggish) at other times. The CAA documented R206's cognition could change throughout the day. The [CONDITION(S)] Drug Use CAA, dated 08/30/19, documented the resident received [CONDITION(S)] medications (medications which affect the mind, emotions, and behavior). Review of R204's physical chart and Electronic Medical Records (EMR) from 08/23/19 to 10/16/19, lacked a comprehensive plan of care. On 10/16/19 at 04:30 PM, Licensed Nurse (LN) J confirmed the comprehensive care plan in R204's EMR was from a previous admission in 2015, and the resident no longer transferred with the assistance of one staff or received a regular diet. On 10/17/19, at 10:01 AM, Administrative Nurse D confirmed a comprehensive care plan had not been competed for R204 and stated completion was a joint interdisciplinary team effort. Administrative Nurse D confirmed the care plan should be completed within the recommended time frame. The facility's Comprehensive Care Plans Standard of Practice policy, dated November 2017, documented the practice of the facility was to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames. The policy documented the comprehensive care plan will be developed within seven days after completion of the MDS assessment. The facility failed to develop a comprehensive plan of care for R204 on admission to the facility, placing the resident at risk for inappropriate care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 55 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to revise the care plan for two of 16 sampled residents, Resident (R) 19 with directions to staff on how to provide care and treatment to prevent pressure ulcers and hospice services information, and R3 for fall interventions after she had three falls. Findings included: - R19's Quarterly-Minimum Data Set (MDS), dated [DATE], documented the resident had short- and long-term memory problems and severely impaired cognition. The MDS documented the resident required total staff assistance with Activities of Daily Living (ADLs) and always incontinent of bladder and bowel. The MDS documented the resident at risk for developing pressure ulcers, had pressure reducing device to her chair, on a turning/repositioning program, and received pressure ulcer care. The revised Skin Care Plan, dated 07/30/19, documented the resident had a pressure reducing mattress on her bed and chair. The care plan lacked information regarding the resident's pressure ulcers, instructions on repositioning, and pressure ulcer care. The Wound Assessment Report Sheet, dated 10/14/19, documented the resident had a pressure ulcer on her right upper back, right top of foot, and right buttock. The Nurse's Note, dated 07/24/19 at 05:53 PM, documented staff placed the resident on bedrest today for skin integrity reasons and instructed staff to reposition the resident every two hours. On 10/22/19 at 10:55 AM, observation revealed Licensed Nurse (LN) G and Certified Nurse Aide (CNA) M entered the shower room and applied dressings to R19's pressure ulcers. Observation revealed the resident had a 0.9 centimeter (cm) by 0.7 cm by 0.2 cm pressure ulcer on her right outer foot, 2 cm by 1.7 cm by 0.4 cm pressure ulcer on her right outer hip, and 4.1 cm by 4.7 cm by 0.4 cm pressure ulcer on her right upper back. Further observation revealed LN G applied [MEDICATION(S)] (wound gel used in the treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . On 10/22/19 at 09:30 AM, Administrative Nurse D verified the resident's care plan lacked instructions to staff regarding repositioning the resident every two hours and pressure ulcer care. The facility's undated Care Plan Revision policy documented changes in a resident's condition always required changes to be made in the plan of care either by change in individual approaches or by the addition of new problems to the plan of care. When changes in condition, medications, treatments or approaches occur, the plan of care would be updated immediately by using the tool care plan change request and would be added to the resident's care plan. The facility failed to update R19's care plan with instructions to staff for repositioning and pressure ulcer care, placing the resident at risk for further skin breakdown and infection. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R19's quarterly MDS, dated [DATE], documented the resident had short- and long-term memory problems and severely impaired cognition. The MDS documented the resident required total staff assistance with ADLs and received hospice services. The revised Comprehensive Care Plan, dated 07/30/19, documented the resident required staff assistance with ADLs but lacked documentation regarding hospice services. The Nurses Note, dated 11/05/18 at 04:58 PM, documented the hospice nurse contacted the facility nurse and received an order to admit the resident to hospice services. The facility's Hospice Agreement, dated 09/07/18 to 09/13/18, documented hospice shall collaborate with the facility on a coordinated plan of care developed jointly between hospice and the facility. On 10/21/19 at 12:52 PM, observation revealed the resident sat in a geri chair (a large, padded, comfortable reclining chair for people with limited mobility) at the dining room table with no signs or symptoms of pain. On 10/22/19 at 09:30 AM, Administrative Nurse D verified the resident's care plan lacked documentation regarding hospice services and stated hospice services should be on the facility care plan. The facility's undated Care Plan Revision policy documented changes in a resident's condition always required changes to be made in the plan of care either by change in individual approaches or by the addition of new problems to the plan of care. When changes in condition, medications, treatments or approaches occur, the plan of care would be updated immediately by using the tool care plan change request and would be added to the resident's care plan. The facility failed to update R19's care plan with hospice services information, placing the resident at risk for lack of coordinated services. - R3's physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The Quarterly MDS, dated [DATE], documented the resident had severely impaired cognition and short- and long-term memory problems. The MDS documented the resident required extensive assistance of one or two staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and supervision with eating. The MDS documented the resident used a wheelchair for mobility. The Falls Care Area Assessment (CAA), dated 10/18/18, documented the resident at high risk for falls and one fall since admission. The CAA documented the resident received diuretics (medication to promote the formation and excretion of urine), narcotics (a drug that relieves pain and induces drowsiness or stupor), and [CONDITION(S)] medications (medications that are capable of affecting the mind, emotions, and behavior) that could increase the risk of falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Falls Care Plan, dated 08/09/19, documented the resident a high risk for falls due to decreased cognition, immobility, pain, and poor safety awareness. The Care Plan instructed staff to assist the resident with transfers, using a sit to stand lift (mechanical lift that raises someone from sitting to standing position), and monitor the resident for bleeding and bruising. The Care Plan instructed staff to notify the physician and the resident's family of falls and injuries as needed, complete a fall assessment on admission, quarterly, and with changes or falls, apply dycem (non-slip material that holds a variety of things in place) to her wheelchair, and apply geri-sleeves (protective sleeve to prevent injury) daily. The Fall Intervention Worksheet, dated 08/30/19, instructed staff to place the resident in a highly staffed area for observation, not documented in the care plan. The Fall Intervention Worksheet, dated 09/19/19, instructed staff to assist the resident up for breakfast, not documented in the care plan. Review of R3's physical chart and Electronic Medical Record (EMR), documented the Care Plan lacked interventions following falls on 08/26/19, 08/30/19, and 09/16/19. On 10/22/19 at 02:07 PM, observation revealed R3 sat in her wheelchair in the special care unit, dycem in place on the seat of her wheelchair, geri sleeves on bilateral upper extremities to the elbow, and participated in an activity with four other residents and activity personnel. On 10/22/19 at 02:34, Administrative Nurse D confirmed the care plan lacked interventions for each fall. The facility's undated Care Plan Revisions policy documented changes in a resident's condition always required changes to be made in the plan of care either by change in individual approaches or by the addition of new problems to the plan of care. When changes in condition, medications, treatments or approaches occur, the plan of care would be updated immediately by using the tool care plan change request and would be added to the resident's care plan. The facility failed to revise R3's care plan with fall interventions, placing the resident at risk for continued falls.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 55 residents. The sample included 16 residents, with two reviewed for nutrition. Based on observation, interview, and record review, the facility failed to monitor and record weekly weights for one of two sampled residents, Resident (R) 204. Findings included: - R204's physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition. The MDS documented the resident required total assistance of one or two staff for bed mobility, transfers, dressing, eating, and toilet use. The MDS documented the resident received 51% or more total calories through his peg tube (tube passed into a patient's stomach commonly used for feeding when oral intake is unavailable or inadequate) and 501 milliliters (ml) or more of fluids. The Nutrition Care Area Assessment (CAA) and Dehydration/Fluid Maintenance CAA, dated 08/30/19, documented the resident had a feeding tube due to dysphagia from frequent seizures and staff monitored the resident's weights. The CAAs documented the resident had no symptoms of dehydration (harmful reduction in the amount of water in the body) during the look back period. The POS, dated 08/23/19, instructed staff to administer [MEDICATION(S)] 1.5 (therapeutic nutrition that provides complete, balanced nutrition for long or short term tube feeding) via peg tube every eight hours for dysphagia. The Nutritional Data Set and Progress Note (NDS), dated 08/28/19, documented the resident's admission weight of 196 pounds (lb) and height of 75 inches. The NDS documented the weight appropriate for the resident's height and recommended staff monitored the resident's weight weekly. The POS, dated 08/28/19, instructed staff to obtain the resident's weight weekly. Review of the resident's Weekly Weights, documented the following weights: 08/28/19 - 196 lb 09/16/19 - 186.3 lb 10/22/19 - 188.8 lb (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/19 at 09:04 AM, observation revealed Licensed Nurse (LN) J entered R204's room, washed her hands and applied gloves, elevated resident's head of the bed 30 to 45 degrees, resident positioned himself on his back, and raised his gown. LN J placed stethoscope to the resident's abdomen, opened the end of the peg tube port, and instilled 10 ml of air by 60 ml syringe into the port. Observation revealed LN J listened and verified placement of R204's peg tube, then removed her gloves, used hand sanitizer, and applied new gloves. LN J inserted the 60 ml syringe into the port of the peg tube and administered [MEDICATION(S)] 240 ml per gravity infusion. Observation revealed LN J administered 100 ml of water per gravity into the 60 ml syringe and closed the port. LN J removed her gloves, replaced resident's gown, and cleaned area. On 10/21/19 at 03:30 PM, LN J confirmed she was unable to locate weekly weights in the resident's records. On 10/22/19 at 11:46 AM, Administrative Nurse D confirmed the Weight Record documented a 5% weight loss from admission on 08/28/19 to 09/16/19 and the lacked documentation of weekly weights as ordered. Administrative Nurse D stated she expected weekly weights be completed as ordered. The facility's Weight Standard of Practice policy, dated November 2017, documented the facility would ensure a resident maintained acceptable parameters of nutritional status, unless clinical conditions demonstrated that was not possible. The policy documented weekly weights would be completed for new admissions and entered into the electronic health record. The facility failed to monitor and record weekly weights for R204, placing the resident at risk for inadequate nutrition.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 55 residents. The sample included 16 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility's consultant pharmacist failed to note staff failed to document Resident (R) 15's pulse prior to administering [MEDICATION(S)] (medication to control heart rate and rhythm) and failed to administer insulin (hormone which regulates the amount of glucose (sugar) in the blood) per physician orders for blood sugars over 350 milligrams per deciliter (mg/dl). Findings included: - R15's Physician Order Sheet (POS), dated 10/03/19, documented diagnoses of diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), [CONDITION(S)] (heart disease), [CONDITION(S)] (rapid, irregular heart beat), and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident received scheduled and as needed (PRN) pain medications, insulin, antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), diuretic (medication to promote the formation and excretion of urine), and opioid (narcotic) pain medications seven days of the lookback period. The Medication Care Plan, dated 07/07/2019, directed staff to administer the resident's medication per physician orders and a pharmacist to review medications monthly. The Physician's Order, dated 07/07/19, directed staff to administer the following medication to the resident: [MEDICATION(S)] (medication to lower blood pressure and pulse), 6.25 milligrams (mg), twice daily, (hold if the systolic (upper number) blood pressure less than 100 millimeters of mercury (mmHg) or pulse less than 50 beats per minute (bpm). [MEDICATION(S)], 0.125 mg, daily, (hold if pulse less than 50 bpm). Novolog (fast acting insulin), 10 extra units for blood sugar greater than 350 mg/dl at time of the blood sugar checks. The Physician Order, dated 07/07/19, directed staff to obtain the resident's blood sugar tests before meals and two hours after meals, do not call if the blood sugar is less than 60 mg/dl or greater than 500 mg/dl. The Medication Administration Record (MAR), dated October 1-21, 2019, recorded staff administered [MEDICATION(S)] six of 17 days without obtaining the resident's pulse. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Blood Sugar record documented blood sugars greater than 350 mg/dl on 08/13/19, 08/07/19, 08/30/19, 08/31/19, 09/06/19, 09/10/19, 09/12/19, 10/08/19, and 10/12/19. The August, September, and October 1-21, 2019 MARs lacked documentation staff administered the physician ordered Novolog for blood sugars greater than 350 mg/dl, nine times. On 10/22/19 at 09:27 AM, observation revealed Licensed Nurse (LN) G administered R15 Novolog insulin, 25 units, subcutaneously (SQ) (beneath the skin). On 10/21/19 at 11:00 AM, LN I verified the MAR lacked documentation staff administered the PRN Novolog insulin or obtained the resident's pulse prior to administering [MEDICATION(S)] or [MEDICATION(S)]. On 10/22/19 at 10:22 AM, Consultant (C) GG stated staff should document blood sugars on the MAR and administer the extra insulin as ordered by the physician. C GG verified staff had not documented if they obtained a pulse prior to administering the [MEDICATION(S)] or the [MEDICATION(S)]. C GG verified it was important staff obtained the resident's pulse or blood pressure to know if the medications should be administered or held. The facility's undated Consultant Pharmacist Services Provider Requirements policy documented the consultant pharmacist provided services including: reviewing the medication regimen of each elder at least monthly and documenting the review and findings in the elder's clinical record, reviewing MARS and physician orders monthly to ensure proper documentation of medication orders and administration of medication to elders, and communicating to the physician and the facility director of nursing potential or actual problems detected. The facility's consultant pharmacist failed to notify the director of nursing or R15's physician when staff failed to document they administered extra insulin for blood sugars over 350 mg/dl or obtained R15's pulse prior to administering [MEDICATION(S)], placing R15 at risk for potential adverse effects.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 55 residents. The sample included 16 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to obtain Resident (R) 15's pulse prior to administering [MEDICATION(S)] (medication to control heart rate and rhythm) and failed to administer insulin (hormone which regulates the amount of glucose (sugar) in the blood) per physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Findings included: - R15's Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident received scheduled and as needed (PRN) pain medications, insulin, antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), diuretic (medication to promote the formation and excretion of urine), and opioid (narcotic) pain medications seven days of the lookback period. The Medication Care Plan, dated 07/07/2019 directed staff to administer medication per physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] [MEDICATION(S)] (medication to lower blood pressure and pulse), 6.25 milligrams (mg), twice daily, (hold if the systolic (upper number) blood pressure less than 100 millimeters of mercury (mmHg) or pulse less than 50 beats per minute (bpm). [MEDICATION(S)], 0.125 mg, daily, (hold if pulse less than 50 bpm). Novolog (fast acting insulin), 10 extra units for blood sugar greater than 350 mg/dl at time of the blood sugar checks. The Physician Order, dated 07/07/19, directed staff to obtain blood sugar tests before meals and two hours after meals, do not call if the blood sugar is less than 60 mmHg or greater than 500 mmHg. The Medication Administration Record (MAR), dated October 1-21, 2019, recorded staff administered [MEDICATION(S)] six of 17 days without obtaining the resident's pulse. The resident's Blood Sugar record documented blood sugars greater than 350 mg/dl on 08/13/19, 08/07/19, 08/30/19, 08/31/19, 09/06/19, 09/10/19, 09/12/19, 10/08/19, and 10/12/19. The August, September, and October 1-21, 2019 MARs lacked documentation staff administered the physician ordered Novolog for blood sugars greater than 350 mg/dl, nine times. (continued on next page)

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	175454	A. Building B. Wing	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/19 at 09:27 AM, observation revealed Licensed Nurse (LN) G administered R15 Novolog insulin, 25 units, subcutaneously (SQ) (beneath the skin). On 10/21/19 at 11:00 AM, LN I verified the MAR lacked documentation staff administered the PRN Novolog insulin or obtained the resident's pulse prior to administering [MEDICATION(S)] or [MEDICATION(S)]. On 10/22/19 at 10:22 AM, Consultant Nurse (C) GG stated staff should document blood sugars on the MAR and administer the extra insulin as ordered by the physician. C GG verified staff had not documented if they obtained a pulse prior to administering the [MEDICATION(S)] or the [MEDICATION(S)]. C GG verified it was important staff obtained the resident's pulse or blood pressure to know if the medications should be administered or held. The facility failed to obtain the resident's pulse prior to administering [MEDICATION(S)] and failed to administer insulin per physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 55 residents. The sample included 16 residents. Based on observation, interview, and record review, the facility failed to provide clean, sanitary food preparation equipment and failed to label or date opened food items in the special care unit refrigerator. Findings included: - On 10/16/19 at 08:17 AM, observation in the special care unit revealed the refrigerator with the following opened, undated items: thickened orange juice, thickened water, container of 2 Cal (calorie and protein dense drink), a two liter bottle of root beer, and two containers of yogurt with an expiration date of 10/08/19. On 10/21/19 at 01:10 PM, observation in the facility kitchen revealed the microwave had dried food crumbs stuck on the inside ceiling and a sticky handle. The dining room kitchenette toaster had a moderate amount of food particles stuck on the handles, base, and trim on the sides. On 10/16/19 at 08:17 AM, Certified Nurse Aide (CNA) N verified staff should have labeled and dated the food items when opened and disposed the items. On 10/21/19 at 02:45 PM, Dietary Staff (DS) BB verified the microwave and toaster needed to be cleaned and stated staff were to clean the equipment after each meal. Upon request, the facility did not provide a cleaning schedule or food labeling policy. The facility failed to ensure staff labeled food items when opened and thoroughly cleaned equipment used to prepare food, placing residents at risk for food contamination.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility had a census of 55 residents. The sample included 16 residents. Based on record review and interview, the facility failed to conduct quarterly Quality Assessment and Assurance (QAA) committee meetings with the facility's medical director present. Findings included: - On 10/22/19 at 03:50 PM, Administrative Staff A stated he could not find records for QAA meetings from January 2019 to September 2019. Administrative Staff A stated he scheduled a QAA meeting in September, invited the facility's medical director to the meeting, but the medical director failed to attend the meeting. On 10/22/19 at 04:25 PM, Consultant (C) HH verified the facility lacked documentation of QAA meetings from January 2019 to September 2019 and the facility's medical director had not attended two of the four quarterly QAA meetings in 2018. On 10/22/19 at 05:10 PM, C GG stated the facility QAA was conducted daily during Stand Up meetings, and staff had not notified the facility's medical director of any of the findings or changes they discussed in the meetings. The facility's Quality Assurance Program Standard of Practice policy, dated November 2017, documented the purpose of the program is to ensure an interdisciplinary approach to residents needs and to provide the highest level of care possible while keeping the interdisciplinary team, physician, and responsible party informed of their condition changes. The policy documented interventions would be implemented as they occur, when necessary on a daily, weekly, monthly basis, and according to regulatory requirements. The facility failed to conduct quarterly QAA meetings with the facility's medical director present, placing the residents at risk for lack of input from the facility's medical director for their overall medical care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 55 residents. The sample included 16 residents, with one reviewed for urinary catheter. Based on observation, interview, and record review, the facility failed to provide interventions to prevent infection for Resident (R) 11 and failed to ensure oxygen treatment equipment was placed in a bag when not in use for residents on three of three halls. Findings included: - R11's Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident required extensive assistance of one to two staff with Activities of Daily Living (ADLs) and had a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Urinary Catheter Care Plan, dated 08/12/19, directed staff to provide the resident catheter care every shift, observe for leaking or obstruction, and provide a leg bag when the resident was out of bed. The Care Plan directed staff to change the drainage bag monthly, keep the tubing free of kinks, and report changes in the characteristics of the urine. The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The Nurse's Note, dated 07/15/19 at 06:37 AM, documented the resident received antibiotics after the surgical insertion of a suprapubic catheter on 07/14/19. The July 2019 Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The August 2019 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . The Laboratory final results, dated 09/03/19, documented a moderate amount of enterococcus faecalis bacteria (bacteria usually spread by poor hygiene). The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The September 2019 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . The suprapubic catheter site Laboratory Culture, dated 10/03/19, documented a large amount of e-coli bacteria (bacteria normally found in the intestinal tract) and large amount of enterococcus faecalis bacteria. The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/19 at 05:00 PM, observation revealed Licensed Nurse (LN) G changed R11's suprapubic catheter site dressing. Observation revealed the skin surrounding the site was slightly pink with no signs of infection or irritation. LN G stated nurses were to change the drain sponge dressing daily. On 10/22/19 at 10:06 AM, Consultant (C) GG stated staff should have performed the suprapubic catheter site dressing change daily and documented in the MAR. On 10/22/19 at 01:35 PM, Certified Nurse Aide (CNA) O stated she changed the resident's suprapubic catheter site sponge today during his bed bath. CNA O stated she observed no redness or drainage and she used wound cleaning spray to clean from the site. CNA O reported the site did not have drainage last week. The facility's undated Skin and Wound Management Program policy documented the nurse manager would oversee the residents' skin or wound care, and the physician will order wound treatments as needed. The facility failed to provide interventions to prevent the development of infection in R11's suprapubic catheter insertion site, placing the resident at risk for complications from the infection. - On 10/22/19 at 05:28 PM, observation revealed oxygen tubing on the floor and unbagged nebulizer treatment (respiratory) equipment in one room on the 100 hall, two rooms on the 200 hall, and three rooms in the 300 hall. On 10/22/19 at 05:35 PM, Administrative Nurse D verified the oxygen and nebulizer equipment needed to be bagged and dated. The facility's undated Administration of Oxygen policy directed staff to store all cannulas, oxygen tubing, and nebulizer masks in a plastic bag when not in use. At no time will oxygen tubing be allowed to drag on the floor, and oxygen tubing will not be draped across bedroom furniture or equipment. The facility failed to ensure oxygen and respiratory treatment equipment was placed in a bag when not in use for residents on three of three halls, placing the residents at risk for contaminated respiratory equipment.